

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-044567

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 170 Primary Registration District No. 4264 Registrar's No. 194

FILED DEC 2 1963

1. PLACE OF DEATH a. COUNTY <u>Laclede</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Laclede</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Conway</u>		c. CITY OR TOWN <u>Conway</u>	
Length of stay in 1b <u>17 yrs.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Within city limits</u>		d. STREET ADDRESS (If outside, give location) <u>within city limits</u>	
3. NAME OF DECEASED (Type or print) First <u>Gilbert</u> Middle <u>Newton</u> Last <u>Thompson</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>22</u> Year <u>1963</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2-8-92</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11a. FATHER'S NAME <u>unknown</u>		11b. MOTHER'S MAIDEN NAME <u>unknown</u>	
12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <u>no</u> <u>none</u>		12b. SOCIAL SECURITY NO. <u>5</u>	
13a. CAUSE OF DEATH (Enter only one cause, time for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Presumed to be "Natural Cause"</u>		13b. NAME OF HUSBAND OR WIFE <u>Florence Thompson</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <u>Investigated by J. J. Shadel, Coroner, Laclede County</u>		14. NAME OF HUSBAND OR WIFE <u>Florence Thompson</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>stomach condition 3 months ago by Dr. RW Frutkin</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>but had no medical attention since</u>	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <u>Conway, Laclede Co., Mo.</u>	
21. I attended the deceased from _____, to _____, and last saw her/him alive on _____ Death occurred at <u>2:40 P.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Shella L. May, Registrar Laclede Co. Let. anon. Mo.</u>		22b. ADDRESS <u>Conway, Laclede Co., Mo.</u>	
22c. DATE SIGNED <u>11-24-1963</u>		22d. LOCATION (City, town, or county) <u>Conway, Laclede Co., Mo.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>11-24-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Conway Cemetery</u>	
24. FUNERAL DIRECTOR <u>J. J. Shadel</u>		25. DATE RECD. BY LOCAL REG. <u>11-24-1963</u>	
26. REGISTRAR'S SIGNATURE <u>Shella L. May</u>		26. REGISTRAR'S SIGNATURE <u>Shella L. May</u>	

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

INSTEAD OF

DATE AMENDED

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

DEC 4 1963

FEB 11 1964

STATEMENT BY LICENSED EMBALMER.

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Brie M. Abbott

Licensed Embalmer No. 5115

P.O. Address Springfield Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

Embalmed - 24-1963 - H.L.D.